Defense Health Agency
Uniform Business Office

Revenue and other Billing Codes, POA and How they Impact Billing

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Objectives

- Understand how revenue codes are used in the billing process
- Revenue Codes – behind the scenes
- Learn how Payers utilize revenue codes
- Revenue Codes and Denials
- Other Billing Codes
- Present on Admission (POA) and why it matters

Background on Revenue Codes

Background:

- Health care facilities must assign the proper codes for services rendered to patient so that the health insurance company can be billed for these services
- It is important for the hospital to represent what it is doing accurately
- Almost all revenue codes require a HCPCS/CPT® code
- This field (FL 43) is used to report appropriate codes for the service performed
- Some payers have edits that will require a specific “detail” revenue code for a specific HCPCS/CPT® code

Background on Revenue Codes

- Revenue codes consist of a four-digit code
- Codes generally include an indication of location, the type of service given and where the service occurred within the facility
- Revenue codes are only used on the paper and electronic Institutional Claim Format (UB-04/837I)

Revenue Code Section of UB-04

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
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16							
17							
18							
19							
20							
21							
22							
23	0001 **PAGE** 1 **OF** 1		**CREATION DATE**		**TOTALS**		

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	XXXXXXXXXX
A		XXXXXX					57	
B							OTHER	
C							PRV ID	

Billing Information on Revenue Codes

- Form Locators (FLs) 42 and 43 are considered “synonymous” data standards (the first represents the data as code/the second represents the data as a narrative description)
- Revenue Codes must be listed in ascending numbered order
- An inpatient bill summarizes the services rendered under a given revenue code category
- An outpatient bill has an itemized listing of all services provided along with corresponding revenue codes and HCPCS codes for each service.
- The 837I standard does not require the description field

Billing Information on Revenue Codes

- The National Drug Code (NDC) is also entered in FL 43 and identifies the ID qualifier, Unit of Measure Qualifier, 11 digit NDC number and the 9 digit quantity.
- NDC ID Qualifier for all claim forms:
  - N4
- Immediately followed by the 11-digit (without hyphens) NDC number
- Immediately followed by the Unit of Measure Qualifier:
  - F2= International Unit
  - GR=Gram
  - ML=Milliliter
  - UN=Unit
- Immediately followed by the 9-digit quantity
- Example: 30 units of product with NDC 12345-123-12 is entered on the UB-04 claim as follows:
  - N412345012312UN000030000

Billing Information on Revenue Codes

- FL 43:
- Contains the HCPCS Descriptor
- (Situational)
- This FL holds the HCPCS codes applicable to outpatient and ancillary services
- Also holds the accommodation description for inpatient claims
- Has 5 positions for the care code plus eight positions for up to 4 modifiers
- Examples of modifiers: (RT, LT, 50)

Billing Information on Revenue Codes

- FL 45 -Service Date
- (Situational)
- The FL states the date the outpatient service was provided
- Not listed on inpatient claims

- FL 46-Service Units
- (Required)
- The FL identifies the unit or quantity of the services provided
- This FL can reflect the number of accommodation days, miles, pints of blood or number of treatments

Examples of Revenue Codes

01xx & 02xx - Room & Board Charges
0250x - Pharmacy
027x - Supplies
03xx - Lab
036x - Surgery
037x - Anesthesia
045x - Emergency Room
076x - Treatment Room

Examples of Revenue Codes

0510 - Clinic-General
0511 - Chronic Pain Center
0512 - Dental Clinic
0513 - Psychiatric Clinic
0514 - OB/GYN Clinic
0515 - Pediatric Clinic
0517 - Family Practice Clinic
0519 - Other Clinic

Linking Revenue Codes to the Revenue Mapping Table

- UBO Revenue Mapping Table
  - Each calendar year the MHS processes the newest CPT® and HCPCS code and links them to the most commonly accepted revenue codes
  - Each code can have up to 5 different revenue codes associated with it
- Currently in TPOCS, the biller can change the revenue code
- With CHCS, the first of the five revenue codes is what appears automatically on the claim

How Payers Utilize Revenue Codes

Payer Requirements:

- Each CPT® and HCPCS code has a range of revenue codes that are payer-acceptable
- Payers can specify what revenue code they require for reimbursement for services provided in a facility
- Because revenue codes help to tell the story - they reflect where the service was performed

Billing Requirements Differ by Payer

- Reimbursement for inpatient stays can be paid by per diem, DRG, MS-DRG, APR-DRG or by case rate
- Outpatient claims can be paid by a percent of charges based on the patient's insurance policy

Listing of Revenue Codes

- To find a full listing of revenue codes see Module 4 of the online web-based course entitled: Data and Billing in Sync – UB-04/837
- Revenue Codes are universal and are used by all payers
- They can be more generic or more specific
- Payers will specify how they wish the service/revenue code to be linked
- Often this is in their contracts or available on their website

Revenue Codes – Behind the Scenes

- There are 22 lines available on a single UB-04 claim form to list revenue codes and charges
- Many systems drop the first digit of the Revenue Code (0) from paper claims
- In the MHS our Revenue Mapping Table matches the most common revenue codes to the current year's CPT®/HCPCS codes
- In the commercial sector Revenue Codes are mapped to the the cost centers that are submitted with the facility's annual cost report

Revenue Codes Impact Denials

- Payers can deny claims that have services associated with a revenue code that does not match the appropriate location for the service
- **Example**: An occupational therapy CPT® code linked to the Operating Room Revenue Code would show up as a mismatch for the Payer, and it would most likely deny the claim
- **Example**: TRICARE and CMS develop a yearly update on procedures that should be performed as “inpatient only” procedures
  - in our Revenue Mapping Table these are mapped to 360/Operating Room to avoid any confusion

Denials and Billing Requirements

Examples:

- Revenue code 250 and Revenue code 636
- HCPCS codes with a J code that includes the name of the drug and the dosage would have a payer requirement to use revenue code 636
- A take home drug, however, would have a 250 (general pharmacy) revenue code
- Check with the payer to see a listing of its revenue codes and how–it requires drugs to be billed on the UB-04/837I

Denials and Billing Requirements

- Some payers demand a specific revenue code associated with a CPT®/HCPCS code for payment
- Denials may occur when the wrong revenue code is indicated
- Revenue codes should be reviewed and corrected if necessary and resubmitted for payment

The Other Billing Codes – Occurrence Codes

Occurrence Codes:

There are 99+ identified Occurrence Codes that are broken into 4 categories:

1. Accident-related codes
2. Medical Condition codes
3. Insurance-related codes
4. Service related codes

Occurrence Codes

- Occurrence codes and dates are used in FLs 31-36 of the UB-04/837I claim format
- The occurrence code and the date field associates and defines a significant event associated with the claim that impacts processing by the payer
- FLs 35-36 are used for Occurrence span codes and dates and are used for reporting the beginning and end dates of the specific event related to the claim

Occurrence Codes

- FLs 31-34 and 35-36 have room for a two-digit code (example: 01) and a date (date of the occurrence)
- The date must fall within the statement coverage date
- These codes identify occurrences that happened over a span of time.
- Enter all dates as month, day, and year (MMDDYY)
- Enter Occurrence Span Codes in alphanumeric sequence

Occurrence Codes

Accident-Related Codes: **(partial listing)**

01 - Accident/Medical Coverage
02 - No-Fault Insurance Involved (including Auto Accident/Other)
03 - Accident/Tort Liability
04 - Accident/Employer Related
05 - Accident/No Medical or Liability Coverage
06 - Crime Victim

Occurrence Codes

Medical-Related Condition Codes: **(partial listing)**

09 - Start of Infertility Treatment Cycle
10 - Last Menstrual Period
11 - Onset of Symptoms/Illness

Occurrence Codes

Insurance-Related Codes: (partial listing)

16 - Date of Last Therapy

17 - Date Outpatient Therapy Plan Established/Last Reviewed

22 - Date Active Care Ended

Occurrence Codes

Service-Related Codes: (partial listing)

40 - Scheduled Date of Admission
42 - Date of Discharge
43 - Benefits Exhausted

The Other Billing Codes - Condition Codes

Condition Codes:

- FLs 18-28 are used for condition codes to report conditions or events related to the bill that may affect the processing of it

Examples:

01-Military Service Related

02-Condition is Employment Related

The Other Billing Codes - **Value Codes**

Value Codes:

- A code structure to relate amounts or values to identify data elements necessary to
- Process this claim as qualified by the payer organization.

Example:

47 - Any liability insurance – amount shown is that portion from a higher liability insurance

50 - Physical Therapy Visit – report the number of PT visits provided from the onset of treatment from this billing provider through this billing period

Background:

- The Deficit Reduction Act of 2005 mandated that providers report POA indicators for all diagnoses submitted on Medicare inpatient acute care claims starting with discharges in 2007
- Present on Admission (POA) is defined as: the conditions present at the time the order for inpatient admission occurs
- The POA indicator is intended to differentiate conditions present at the time of admission from those conditions that develop during the inpatient admission.

Background on POA

Background Continued:

- Secondly, the Deficit Reduction Act also mandated reduction of hospital-acquired conditions (HACs)
- These are identified through the reporting POA indicators
- The goal is to improve hospital quality and identify and measure Patient Safety
  - The POA indicator facilitates the measurement of patient quality of care for those payers who reimburse based on quality

Present on Admission (POA)

- POA is defined as a condition or diagnosis present at the time the order for inpatient admission occurs
  - Assigned by coders based on documentation
- Conditions that develop during an OP encounter (including ED, Observation or OP surgery) are considered as POA
- The POA indicator is assigned to principle and secondary diagnoses and external cause of injury codes (E-codes)
- Will identify hospital-acquired conditions and infections

Background on POA

POA Indicators:

Reporting Options and Definitions:

- Y = Yes = present at the time of inpatient admission
- N = No = not present at the time of inpatient admission
- U = Unknown = the documentation is insufficient to determine if the condition was present at the time of inpatient admission.
- W = Clinically Undetermined = the provider is unable to clinically determine whether the condition was present at the time of inpatient admission or not
- 1 = Unreported/Not used - Exempt from POA reporting.

POA Examples

Examples for External Cause of Injury Codes:

- Y indicator is assigned to any E code representing an external cause of injury or poisoning that occurred prior to the inpatient admission (patient fell out of bed at home or in the ED prior to admission)
- N indicator is assigned for any E code or poisoning that occurred during an inpatient stay (patient fell out of bed in the hospital or had an adverse reaction to medication administered after inpatient admission

What Are “Never Events”?

- Payers determine whether they will reimburse for adverse events [Example: Patient is admitted for MI (myocardial infarction) and develops a pressure ulcer – will be reimbursed for care related to the heart attack but not for the pressure ulcer]
  - Object left in surgery
  - Air embolism
  - Delivery of incompatible blood products
  - Catheter-associated urinary tract infections
  - Decubitus pressure ulcers
  - Vascular catheter-associated infections
  - Mediastinitis after CABG surgery
  - Hospital-acquired injuries – Fractures, dislocations, intracranial injury
  - Crushing injury; burns

- *Identified in the FY 2008 – Inpatient Prospective Payment System Final Rule*

Why POA Matters?

- What the Documentation Will Reflect
  - Was the condition present and diagnosed prior to the inpatient admission?
  - Did the condition require any additional investigation?
  - What were underlying causes of signs and symptoms?
  - Was the condition suspected, possible, probable, or to be ruled out?
  - Any external causes of injury or poisoning?
  - Any acute and/or chronic status of condition(s)?

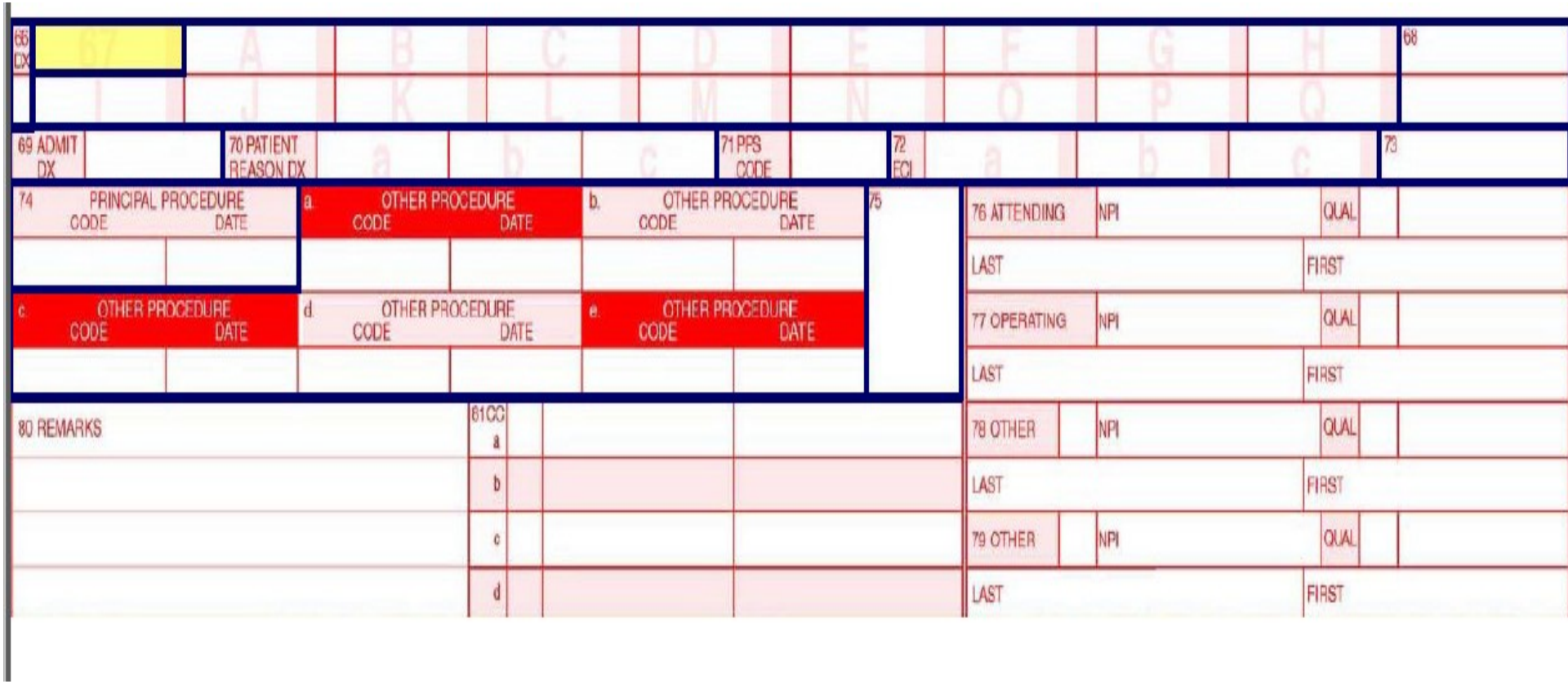
Outpatient to an Inpatient Status

What if the patient starts out in the Emergency Room and then is admitted?

- When an outpatient is admitted to inpatient status, the conditions documented for the outpatient encounter are considered to be present on inpatient admission
- Assign “Y” for these cases
- Diagnoses from ER are considered present on admission

Where POA is Listed on the UB-04

- POA goes on FL 67 and on the 837I
- Version 5010: POA is reported in HI01-9 and corresponds to the diagnosis reported in HI01-2



Summary Slide

- Proper billing codes are required for payers to reimburse claims
- Understanding how these codes can impact reimbursement and create denials is important
- For a more in depth study of the data elements required on the UB-04/837I claim form, please visit the UBO Learning Center website and register for the online web-based course entitled: Data and Coding in Sync – UB-04/837I

Thank You

Questions?

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